HMO/AFDS Profile of Contracted Health Professionals

Name of Applicant: _____

Requested County: _____

For each county in the applicant's requested service area, provide the following information for each contracted primary care and specialist health professional. Add or delete rows as needed. For **AFDS**, enter contracted health professionals under "Other Specialists."

Primary Care Providers

Family Practice

Provider Name	Board Eligible or Certified (Yes/No)	City	Accepting New Patients (Yes/No)	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:				

General Practice

Provider Name	Board Eligible or Certified (Yes/No)	City	Accepting New Patients (Yes/No)	Admitting Privileges to a Participating Hospital (Yes/No)
	N/A			
	N/A			
	N/A			
	N/A			
	N/A			
Total Number of Providers:				

Internal Medicine

Provider Name	Board Eligible or Certified (Yes/No)	City	Accepting New Patients (Yes/No)	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:				

OB/GYN

Provider Name	Board Eligible or Certified (Yes/No)	City	Accepting New Patients (Yes/No)	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:				

Pediatrician

Provider Name	Board Eligible or Certified (Yes/No)	City	Accepting New Patients (Yes/No)	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:				

Specialists

Allergists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Anesthesiologists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Cardiologists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Dermatologists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Gastroenterologists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Orthopedists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Radiologists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

General Surgeons

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Urologists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Psychiatrists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Other Specialists

For other contracted specialists, provide the requested information in the same format. Repeat the format and add additional pages as necessary.

Identify Other Specialists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Identify Other Specialists

Provider Name	Board Eligible or Certified (Yes/No)	City	Admitting Privileges to a Participating Hospital (Yes/No)
Total Number of Providers:			

Officer Certification: I certify that the information reported is complete and correct.

_____ _____

Signature of Authorized Representative Date Signed

_____

Authorized Representative Name and Title *(type or print)*

Telephone Number: _____ E-mail Address: _____

_____

Contact Person *(type or print)*

Telephone Number: _____ E-mail Address: _____

PA 252 of 2000 requires submission of this form. Failure to complete and submit this form could result in denial of the application for a certificate of authority.